MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL

SUBJECT: Speech Therapy (S.T.) APPLIES TO: MHP☒ MLTCP☒ MSSP☒ HEALTHSELECT☒	Protocol #: PA P229.01 Protocol Pages: 1 Attachments: Yes☐ No☒ Initial Effective Date: June 1999 Latest Review Date: May 2002

MIHS HEALTH PLANS APPROVALS:

Director, Medical Management:_____ Date:_____

Medical Director:_____ Date:_____

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Speech Therapy (S.T.). Medically necessary speech services are provided to all members on an inpatient basis. Speech therapy provided on an outpatient basis is covered only for EPSDT and ALTCS members, MSSP and HealthSelect. Outpatient speech therapy is not covered for Maricopa Health Plan (MHP) members over the age of 21.

PROTOCOL:

A. Speech Therapy (S.T.)
CPT: 92507-92508

B. The prior-authorization specialist may approve if:
1. The member had functional communicative and/or swallowing skills prior to the event – **and**

2. The member's medical condition requiring services is acute (less than 4 months old).

C. A maximum of 6 sessions will be authorized (2 weeks, 3x a week) before reassessment for functional communicative disorders and/or swallowing skills. Assessment of swallowing/aspiration concerns is one session only.

D. Speech Therapy for hearing impairment can only be authorized by the Medical Director.

E. Training for laryngeal (esophageal) speech, or use of electrolarynx may be initially authorized for 10 sessions. Reassessment will be needed for further treatments.

F. Home Therapy for functional communicative disorders may continue until patient is no longer homebound and then transitioned to out-patient

G. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

H. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

I. If requirements are not met, Medical Director review is required.